**CONSENT TO CONTACT FOR RESEARCH PURPOSES**

**TITLE:** The Fourth **L**eft **A**trial **A**ppendage **O**cclusion **S**tudy (LAAOS-4)

**SPONSOR:** Hamilton Health Sciences Corporation through its Population Health Research Institute (PHRI)

PRINCIPAL INVESTIGATOR: Dr. Stephen Wilton (403-210-7102)

You are being invited to give consent for Dr. Wilton, or a qualified member of his study team, to contact you at some time in the future to invite you to participate in a research study.

Are you willing to learn more about this study? (Circle one)

YES NO

If yes, you will be contacted at a later date. Please include your contact information below.

**Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You authorize your health service provider to share your name, email address, and phone number with the research team for the purpose of being contacted to learn more about the research study,“LAAOS-4”.

Every effort will be made to safeguard your contact information. Although access to this information will be limited, there is a small chance that this information could be inadvertently disclosed or inappropriately accessed. You have been made aware of the reasons why the contact information is needed and the risks and benefits of consenting or refusing to consent. This consent is effective immediately. Your consent to be contacted can be revoked by you at any time.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_